TESTIMONY IS EMBARGOED UNTIL 9:00 AM FRIDAY, APRIL 27, 2012

Statement of The Honorable John Breaux
Subcommittee on Health, Committee on Ways and Means
US House of Representatives
April 27, 2012

Chairman Herger, Ranking Member Stark and members of the Committee, thank you for inviting me to testify on what is both one of the most important and at the same time divisive issues of our time – Medicare.

Let me say that I had the privilege of serving in Congress for 32 years, 14 in the House and 18 in the Senate. I fully understand the difficulties each Member has in addressing what needs to be done in providing healthcare to our nation's seniors. I have observed over the years some Democrats, not all, have taken the position that in healthcare, the government should do everything and the private sector should do nothing. On the other side, there are some Republicans, not all, who argue the opposite – government should do nothing and the private sector should do it all.

My opinion is that in order to ever reach an agreement; Congress must combine the best of what government can do with the best of what the private sector can.

I would submit this is exactly what we did in creating Medicare Part D. The best of what the government can provide is:

1. Help pay for the program.
2. Set up the mechanics and structure of the program with standards
3. Make sure the companies do not scam the system and can actually deliver the product.

The private sector can:

1. Create competition which lowers prices
2. Bring innovation and new products to the market
3. Deliver beneficiaries choices to allow selection of the best plan for them.

Our current Medicare program was signed into law by President Lyndon Johnson in 1965. The model chosen to deliver those health benefits 47 years ago was the "fee for service" model. Providers do the service and the government pays the fees. To control costs, the government fixes the price for everything from bedpans to brain surgery. Providers now get around the cost caps by doing more services and the program has remained much the same for 47 years.

A former colleague of mine in the United States Senate was Harris Wolford from Pennsylvania. Senator Wolford was a truly committed liberal who served with great distinction in the Kennedy Administration, as well as the Senate. He argued strongly that every American citizen should have access to the same quality healthcare that his or her Member of Congress receives. He argued that if it was good enough for Congressmen, it should be good enough for all Americans.

What each of you, your staffs and millions of other federal employees have (and I have as a retired federal employee), is a health plan that combines the best of what government can provide with the best of what the private sector can offer.

The Federal Employees Health Benefits Program (FEHB) enacted in 1959 required that the federal government write the regulations that set up the program and then pays up to 75% of the cost of the health benefits. The beneficiary then pays the rest based on a formula set by law. Over 350 private health plans are offered under the program - 14 are fee for service and the remainder are what is called premium support. Premium support programs have the government paying 75% of the premiums and approve a select group of private plans that employees can choose from that are

required by our government to deliver services. All of this is implemented and enforced by the Federal Office of Personnel Management (OPM).

When I chaired the national Bipartisan Commission on the Future of Medicare in 1998 and 1999, we examined several options on how to improve Medicare. No one, republican or democrat, wanted to end federal Medicare and a strong majority (10 of the 17) supported a new delivery system based on a market based premium support system where for most seniors, premium support would be set at about 88% of the standard plan. Unfortunately, the statute creating our Commission did not require a majority to report, but a super majority, so our Commission plan was never formally submitted to the President or Congress. However, what happened next was then Republican Leader Bill Frist and I developed complete statutory legislation and introduced S. 1895 which incorporated the fundamental principles of the Medicare Commission proposal.

The core recommendation of our bill was not to end Medicare, but rather to restructure Medicare using what each of you have today, the FEHB Program as a model. Under our bill, beneficiaries would be subsidized by the federal government for participation in any competing private or government plans offered under Medicare, including the existing Medicare fee for service program.

The contribution amount by the federal government would be based on the national average, weighted by plan enrollment and adjusted for risk and geography, of the premiums for a standard benefit package. Updates would be based on actual health care costs at that time—NOT some arbitrary growth rate like GDP. That standard benefit package would be "all services guaranteed under the existing Medicare statute."

Breaux-Frist set the overall Medicare contribution at 88% of the national average cost of the standard benefit package. Under our plan, the amount of Medicare's contribution would be guaranteed. Also, importantly, under our plan, in rural areas where competition is less likely, beneficiaries would be protected from paying premiums that are higher than the current Part B premiums.

Finally, we established a Medicare Board. This board would oversee competition among private and government sponsored fee for service plans and would be the equivalent to the Office of Personnel Management which today manages the FEHB Program. It would exercise its authority by regulation and negotiate with the plans. Overall, the Commission estimated its proposal would reduce the Medicare growth rate by 12%.

Some good news is that in addition to the important changes the Affordable Care Act (ACA) made to those under 65 in the private insurance market (through exchanges, etc), it also included promising reforms moving away from traditional FFS Medicare, but still under a fee for service program. Things like value-based purchasing and bundled payment systems where CMS will try to realign incentives and reimburse doctors and hospitals for the quality of care they provide rather than the quantity. Under the ACA, CMS has already started testing new and innovative payment and delivery programs through the Center for Medicare and Medicaid Innovation (CMMI). The goal of all of these payment reforms and demonstration projects in the ACA is to improve patient outcomes while lowering costs. In the event that we move to a premium support model where there is more price competition between FFS and private plans, the whole system would be better off if these promising FFS Medicare reforms in ACA work.

The great challenge today is how do both political parties bridge the gap between different philosophies and produce healthcare reform for America's seniors. In 1965, a bipartisan Congress said fee for service was the best delivery system, let me suggest that in 2012, the best delivery system is contained in the Breaux-Frist proposal.

Thank you for your attention.